New 11/05
DPHHS-HPS/BSRx-001

Big Sky Rx Program Application

Big Sky Rx is a State of Montana program to help qualified Medicare Montana residents pay for Medicare monthly prescription drug premiums. Please read our application cover for eligibility information. If you have questions or need help completing this application, call us toll-free in-state at 1-866-369-1233 or 1-406-444-1233 from out-of-state or in the Helena area. Please print in all CAPITAL letters. It is **IMPORTANT** that you **fill in** all sections. Missing information will cause delays.

Answer the questions separately for you and your spouse if you are married and living together. Please print. Use capital letters.

1. **Applicant's Name:**

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MI ☐ Suffix (Jr, Sr, etc) ☐☐☐

Spouse's Name: If you are married and living together.

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MI ☐ Suffix (Jr, Sr, etc) ☐☐☐

Send Application to:
Big Sky Rx Program
PO Box 202915
Helena, MT 59620-2915

This does not enroll you in a Medicare Prescription Drug Plan or Social Security Extra Help.

2. Are you applying for Big Sky Rx? ☐ Yes ☐ No

   Spouse ☐ Yes ☐ No

3. Applicant's Social Security Number ☐☐☐–☐☐–☐☐☐☐

   Spouse ☐☐☐–☐☐–☐☐☐☐

4. Applicant's Medicare # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

   Spouse ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5. Applicant's Date of Birth (Month-Day-Year) ☐☐/☐☐/☐☐☐☐

   Spouse ☐☐/☐☐/☐☐☐☐

6. Applicant's Gender ☐ Male ☐ Female

   Spouse ☐ Male ☐ Female

7. Home Phone Number ☐☐☐–☐☐☐–☐☐☐☐

8. Home Street Address

9. Mailing Address (if different from home address)

10. City, State, and Zip Code

11. Email Address (optional)

    Spouse Email (if different)

12. Are you a Montana resident? ☐ Yes ☐ No

    Is your spouse a MT resident? ☐ Yes ☐ No

13. Are you a member of a Tribe? (Optional)

Applicant ☐ Yes ☐ No Tribe Name: _____

Spouse ☐ Yes ☐ No Tribe Name: _____

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14. Family Size: Your living situation may affect the amount of help you can receive. Therefore, we need to know how many relatives live with you and/or your spouse and depend on you or your spouse to provide at least one-half of their financial support. Relatives include anyone related to you by blood, marriage or adoption. **Do not include yourself or your spouse in this number. Check only one box.**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

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15. Family Income: If you (and/or your spouse, if married and living together) receive income from any of the sources listed below, please enter the **total monthly income. If the amount changes from month to month, enter the average monthly income for the past year for each type** in the appropriate boxes. **Do not list** income tax refunds, wages and self-employment, interest income, public assistance, medical reimbursements or foster care payments here. **If no income** is received from the source check the NONE box.

Social Security Benefits	☐ NONE	$ ☐☐☐,☐☐☐
Railroad Retirement	☐ NONE	$ ☐☐☐,☐☐☐
Veterans Benefits	☐ NONE	$ ☐☐☐,☐☐☐
Lease/Net Rental Income	☐ NONE	$ ☐☐☐,☐☐☐

If you have any other income, please list it in the space(s) below. Examples include: Public or Private Pensions, Annuities, Worker's Compensation, Dividends, Interest, Alimony, Income From A Trust, Inheritances, Conservation Reserve Program (CRP).

_____ $ ☐☐☐,☐☐☐

_____ $ ☐☐☐,☐☐☐

No Family Income ☐

16. Wages: What do you expect to earn in wages before taxes **this year? Include** wages, tips, net earnings from self-employment, royalties, and honoraria.

Applicant: ☐ NONE $ ☐☐☐,☐☐☐

Your Spouse: ☐ NONE $ ☐☐☐,☐☐☐

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17. In-kind: Does anyone provide or help you (or your spouse, if married and living together) pay for any of the following household expenses — food, mortgage, rent, heating fuel or gas, electricity, water and property taxes? (Do not include food stamps, house repairs, help from a housing agency, an energy assistance program, Meals on Wheels, or help with medical treatment and drugs.)

If you put an **X** in the **YES** box, enter the monthly amount, or if the amount changes each month, enter the average monthly amount for the past year.

☐ Yes ☐ No $ ☐☐☐,☐☐☐

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18. Disability or Blindness Work-Related Expense: Do you (or your spouse, if married and living together) have to pay for things that enable you to work? We will count only a part of your earnings toward the income limit if you work and receive Social Security benefits based on a disability or blindness and you have work-related expenses for which you are not reimbursed. Examples of such expenses are: the cost of medical treatment and drugs for AIDS, cancer, depression, or epilepsy; a wheelchair; personal attendant services; vehicle modifications, driver assistance or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

Disability			**Blindness**		
Applicant:	☐ No	☐ Yes	Applicant:	☐ No	☐ Yes
Your Spouse:	☐ No	☐ Yes	Your Spouse:	☐ No	☐ Yes

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19. Family Assets: Assets are not counted for the Big Sky Rx Program. We collect this information in case you might be eligible for the Federal program called Social Security Extra Help. Extra Help can pay for Medicare prescription drug plan co-payments, deductibles, and premiums. We will notify you if your income and asset information look like you might be eligible for the Extra Help so you can apply. List the total value of your assets. **Total value of any** financial institution accounts (including checking, savings, certificates of deposit, retirement accounts, such as Individual Retirement Accounts (IRA), 401(k) accounts and similar items), stocks, bonds, savings bonds, mutual fund shares, or other similar investments, cash, life insurance policies with a total face value of $1,500 or more,

and any other real estate other than your home and the property on which it is located, investments and real estate other than your home. If you are single, assets need to be less than $11,500 to qualify for Extra Help. If you are married and living together, assets need to be less than $23,000 to qualify for Extra Help. Include the things you own by yourself, with your spouse or with someone else. **Do not include your home, vehicles, burial plots or personal possessions.**

List Asset Value: $ ☐☐☐,☐☐☐

20. Medicare Prescription Drug Plan Information:

Have you signed up for your Medicare prescription drug coverage plan?

Applicant: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If yes, what is your Medicare drug coverage plan name?

What is your **spouse's** Medicare drug coverage plan name?

If you have not yet signed up for a Medicare prescription drug coverage plan please continue to fill out this application and mail it to Big Sky Rx. When we receive your application, we will determine if you are qualified for Big Sky Rx. If you are qualified, we will send you a letter asking for your prescription plan information. You cannot be enrolled until we receive this information.

If you have signed up for a Medicare prescription drug plan, how is your premium paid?

Self Spouse (If living together and applying for Big Sky Rx.)

☐ ☐ Check here if your monthly drug plan premium is not taken out of your Social Security check and you pay the premium to your prescription drug plan. If you qualify for Big Sky Rx, the program will **pay your premium directly to your prescription drug plan.**

☐ ☐ If your monthly drug plan premium is taken directly out of your Social Security check and if you qualify for Big Sky Rx Program: Check here if you want the monthly premium amount from Big Sky Rx **directly deposited** to your bank account. (If you want direct deposit, the State Big Sky Rx Program will send you the direct deposit forms to complete.)

☐ ☐ If your monthly drug plan premium is taken out of your Social Security check and if you qualify for Big Sky Rx Program: Check here if you do not want direct deposit. We will **send** the check to your home address listed on your Medicare Rx information application.

21. Other Contact: If you would prefer that we contact someone else if we have additional questions or if someone else is assisting you, please provide the person's name and a daytime phone number. By listing this person it gives us your permission to share your Big Sky Rx program information with them. (Please Print)

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Phone Number ☐☐☐–☐☐☐–☐☐☐☐

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22. My signature on this application indicates: I understand that by submitting this application, I am declaring under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime. I know I must provide any documentation related to this application if requested. Failure to do so will result in ineligibility or closure of benefits. I understand that the Big Sky Rx Program may check my statements and compare my records from Federal, State, and local government agencies, with my application to make sure the determination is correct. By submitting this application, I am authorizing Big Sky Rx to obtain and disclose information related to my income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, insurance policies, benefits, and pensions. If I knowingly give false information to enroll in Big Sky Rx, I understand that I must reimburse Big Sky Rx for any costs incurred. If an audit proves I am over income, I know I will be disenrolled as of the following month from Big Sky Rx. If I change my address, am no longer a Montana resident, change Medicare Prescription Drug Plans or have a change in Extra Help (if applicable), I must report the change to Big Sky Rx within 20 business days. **All applicants must sign. Keep a copy of this application for your records.**

Signature of Applicant _____

Date _____

Signature of Spouse _____
(if applying for Big Sky Rx)
Date _____

Signature of Representative _____
(if applicable)
Date _____

Send In Your: Big Sky Rx Application
Copy of Enrollment Information
(Medicare Prescription Drug Plan)
Copy of Your Extra Help Determination
(if applicable)

Send To: Big Sky Rx Program
PO Box 202915
Helena, MT 59620-2915

Contact Us At:	1-866-369-1233	Toll Free From In State
	1-406-444-1233	Out Of State and Helena
	1-406-444-1861	Fax
	bigskyrx@mt.gov	Email
	www.bigskyrx.mt.gov	Website

MONTANA
Department of Public Health & Human Services

AFFIX
POSTAGE
HERE

Big Sky Rx Program
PO Box 202915
Helena, MT 59620-2915